

Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as a hearing aid specialist. It is strongly suggested that you read the regulations prior to filling out the application, and then examine the directions entitled "**STEPS TO LICENSURE**" to see which forms are appropriate for you.

Please note the following:

- (a) Applications not completed in their entirety will be returned, minus the applicable fees, which are non-refundable.
- (b) The photograph must be a "passport-style photo."
- (c) The names on the application and the licensure requirements must be the same or a copy of the legal document(s) effecting the name change(s) must be included with your application. The name on the driver's license or U.S. Social Security Card must be the same as the name on the application. We will not accept nicknames, abbreviations, or alterations.
- (d) The home address on the application is considered the address of record until a license is issued to you. Following licensure, all official correspondence will be sent to your employer's address. Written notice signed by the applicant is required for all address changes.
- (e) All checks/money orders are made payable to the Mississippi State Department of Health.
- (f) Our overnight mail address (see "**OVERNIGHT MAIL**") is as follows:

Mississippi State Department of Health  
Professional Licensure - HAS  
570 East Woodrow Wilson Blvd.  
Jackson, MS 39216

Please be advised that it is illegal to practice or represent oneself as a hearing aid specialist in Mississippi unless currently licensed in accordance with the provisions of these regulations.

If you have any questions regarding the above, please contact my office directly.

Sincerely,

Yolanda Morrow  
HPS, Sr.

# STEPS FOR LICENSURE

Enclosed is a licensure packet for hearing aid specialists. The requirements are as follows:

1. Completed application.
2. Non-refundable fee (\$100.00).  
**NOTE:** An additional \$100.00 fee, prorated quarterly, will be assessed an individual prior to a regular license being issued by this office. The additional prorated fee is an administrative action that places the licensee in the regular licensure, odd-numbered year, renewal cycle.
3. Notarized copy of high school diploma/GED certificate (minimum requirement) or the highest awarded education level.
4. Verification of all licensure, current or not current, reported directly to this office from the licensing authority, if applicable.
5. Signed Supervision Agreement (see enclosed memo and form) - temporary license applicants only
6. Effective July 1, 1999, the International Licensing Examination (ILE) for the Hearing Instrument Dispenser by the International Institute for Hearing Instrument Studies is the recognized exam. ILE results and practical exam results must be reported from the examining authority, if applicable, or please refer to the enclosed memorandum for information about sitting for the licensure exam.

**NOTE:** The practical exam results from other states will be evaluated on a case-by-case basis. Candidates must pass all competency areas on the ILE. Both the ILE and the practical exam must have been taken within the last 12 months. An exam on Mississippi Law is required for all applicants.

All requirements must be satisfactory to this office before a license may be issued. A license must be issued prior to seeing clients.

If further assistance is needed, please contact my office.

Enclosures:

1. Application for License
2. Supervision Agreement
3. Verification of License in Another State
4. Request to Schedule the Hearing Aid Specialist Licensure Exam
5. Supervisor Requirements Memorandum

# REQUEST TO SCHEDULE THE HEARING AID SPECIALIST LICENSURE EXAM

**Instructions:** Complete the form, attach the exam fee (payable to MSDH), and mail to the Professional Licensure Branch prior to the end of the exam registration period. All licensure requirements must be on file and satisfactory to this office before an applicant will be allowed to sit for the exam.

## **Applicant:**

1. Name: \_\_\_\_\_
2. Social Security #: \_\_\_\_\_
3. Request for Special Accommodations under the Americans with Disabilities Act (ADA) - Circle one YES NO

*If yes, please submit all documentation supporting your request with this form and the exam fee prior to the exam registration deadline.*

I, the undersigned, do hereby certify and affirm, under the penalties of perjury, that the information contained on this form, and, if applicable, submitted in support of it, is true to the best of my knowledge and belief.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

July 1, 1995

MEMORANDUM

TO: Temporary License Applicants

FROM: Stephanie Boyette, Health Program Specialist, Sr.  
Professional Licensure

RE: Supervisor Requirements

---

Before a temporary license may be issued, a supervised training experience form must be on file in this office.

Please find enclosed a form detailing the minimum supervised training experience required for all temporary licensees per Section 10-3 of the *Regulations Governing Licensure of Hearing Aid Specialists*. This form includes a statement of supervision from the licensee. The supervisor and temporary licensure applicant should sign this form and return it to this office with the temporary licensure application.

The licensed supervisor must meet at least one of the following criteria per Section 10-1 of said regulations:

- (a) Holds a current and valid document of being National Board Certified in Hearing Instrument Sciences by the International Hearing Society (IHS); or
- (b) Holds a current and valid Certificate of Clinical Competence in Audiology from the American Speech-Language-Hearing Association (ASHA); or
- (c) Has had a minimum of three (3) years' experience in the testing of hearing, fitting of hearing aids and dispensing of hearing aids.

A copy of the supervisor's relevant current certificate/card or proof of experience must be submitted with the temporary license application.

If there are any questions concerning this matter, please contact my office.

# Application for License



MISSISSIPPI  
STATE DEPARTMENT OF HEALTH

## Office Use

Check No. \_\_\_\_\_

Amount \$ \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Please type or print in ink)

### License Type

Regular ☐ Temporary ☐

### Personal

Name:

(Last)

(First)

(Middle)

Home Address: \_\_\_\_\_

(City)

(State)

(Zip Code)

(County)

Telephone Number (\_\_\_\_) \_\_\_\_\_

U.S. Social Security No.  -  - Date of Birth:  -  - 

Race: \_\_\_\_\_

Sex: Male ☐ Female ☐U.S. Citizen: No ☐ Yes ☐Legal Alien: No ☐ Yes ☐

Visa Type &amp; No.: \_\_\_\_\_

### Employment

Employer:

Business Address: \_\_\_\_\_

(City)

(State)

(Zip Code)

(County)

Telephone Number (\_\_\_\_) \_\_\_\_\_

Worksite Address: \_\_\_\_\_

(City)

(State)

(Zip Code)

(County)

Telephone Number (\_\_\_\_) \_\_\_\_\_

### Education

Attach a copy of diploma or Verification of Education. CCC-A attach copy of current Certified Member Card. BC-HIS applicants attach copy of current card.

Check highest level of education.

Date Awarded: \_\_\_\_\_

GED ☐  
MA ☐HS ☐  
MS ☐BA ☐  
PhD ☐BS ☐  
Other \_\_\_\_\_

### Licensure

Have you ever been licensed or registered in another state, territory or country? No ☐ Yes ☐ If yes, list all licenses (current/not current). *All licenses must be verified by the licensing authority - with board seal. (See Verification of Licensure Form.)*

1. \_\_\_\_\_

3. \_\_\_\_\_

5. \_\_\_\_\_

7. \_\_\_\_\_

2. \_\_\_\_\_

4. \_\_\_\_\_

6. \_\_\_\_\_

8. \_\_\_\_\_

Have you ever had a license or permit encumbered in any way, i.e., revoked, suspended, rejected, placed on probation, etc? If yes, a full disclosure is required from the licensing board before a license may be issued. No ☐ Yes ☐

Have you ever been convicted of any violations of law except for minor traffic violations? No ☐ Yes ☐

Are there any criminal or civil suits pending against you? If yes, attach a full explanation. No ☐ Yes ☐

**Supervision**

*Temporary licensure applicants only.* Enclose completed Supervision Agreement.

**Examination**

Have you ever taken the NIHIS exam? No ☐ Yes ☐ If yes, exam scores must be reported directly from the testing authority .

**Fees**

    \$100.00     Application/License - \$100.00 (non refundable)

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

\_\_\_\_\_  
(Applicant's Signature)

Complete form, enclose fee and mail to:  
**Mississippi State Department of Health**  
**Professional Licensure: Hearing Aid Specialist**  
**P. O. Box 1700**  
**Jackson, Mississippi 39215-1700**

**Attach Copy  
of Driver's License  
or  
U.S. Social Security Card**

**Attach Photo**

Subscribed and sworn to before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 19 \_\_\_\_\_.  
My commission expires \_\_\_\_\_.

\_\_\_\_\_  
(Notary Public)

Hearing Aid Specialist

# Verification of License in Another State

**To be Completed by Applicant** *(Please print or type)*

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name: \_\_\_\_\_

Licensing Authority: \_\_\_\_\_ Number: \_\_\_\_\_ Date Issued: \_\_\_\_\_  
*(State, Territory, or Country)*

\_\_\_\_\_  
*(Applicant Signature)*

**To be Completed by Secretary of Licensing Board**

Licensee's Name: \_\_\_\_\_

License Type (HAS): \_\_\_\_\_

License Number: \_\_\_\_\_

Date Issued: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Licensed By: \_\_\_\_\_ NIHIS Exam: \_\_\_\_\_

Reciprocity with: \_\_\_\_\_

Other: \_\_\_\_\_

Has license ever been disciplined? ☐ No ☐ Yes *(if yes, please attach findings and disposition.)*

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Licensing Board must return to:**  
Mississippi State Department of Health  
Professional Licensure: HAS  
Post Office Box 1700  
Jackson, Mississippi 39215-1700

\_\_\_\_\_  
*(Authorized Signature)*

This document must show Seal of licensing agency.

*Seal*



Hearing Aid Specialist

# Supervision Agreement

(Please type or print in ink)

## Temporary License Applicant

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code) (County) Telephone Number (\_\_\_\_) \_\_\_\_\_

## Supervising Hearing Aid Specialist

Mississippi License Number: \_\_\_\_\_

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code) (County) Telephone Number (\_\_\_\_) \_\_\_\_\_

Beginning Date of Supervision: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Supervisor Credentials

Check box(es) where applicable and attach copy of current credential(s):

1. Currently hold the National Board for Certification in Hearing Instrument Sciences (NBC-HIS) Certificate ☐
2. Currently hold the ASHA Certification of Clinical Competence (CCC-A) ☐
3. Have held licensure in Mississippi for at least three (3) years ☐

**Any changes in this agreement must be reported to the Mississippi State Department of Health, Professional Licensure Branch within 10 working days.**

I, the undersigned, do solemnly swear or affirm that I am the above licensee. I have read the above agreement and all statements contained therein or accompanying this agreement are true to the best of my knowledge and belief. I agree to adhere to the rules and regulations governing the supervision of Temporary licensees and will provide the applicant with the training listed in Section 10-3 of the regulations.

\_\_\_\_\_  
(Temporary Licensee Applicant Signature)

\_\_\_\_\_  
(Supervising Licensee Signature)

Complete form and mail to:  
**Mississippi State Department of Health**  
**Professional Licensure: Hearing Aid Dealers**  
**Post Office Box 1700**  
**Jackson, Mississippi 39215-1700**

